

FY

Amendment #, If Applicable:

If Federal Funds, CFDA #:

for internal DMR use) within FY amendment #:

ATTACHMENT 1: PROGRAM COVER PAGE**PROGRAM INFORMATION**

Contractor Name:	Department of Mental Retardation
Program Type:	Document ID #
Program Name:	UFR Program #:
Program Address:	MMARS Program Code:
City/State/Zip	Other Reference Information (Information Purposes Only):
Contact Person:	Contact Person:
Telephone:	Telephone:

RFR INFORMATION: Attached legislative exemption RFR Reference # emergency collective purchase interim amendment

SCOPE OF SERVICES: Bidders Response Attached Description of Services Attached

TOTAL ANTICIPATED CONTRACT DURATION: to

INITIAL DURATION: to

OPTIONS TO RENEW: options to renew for years each option

FISCAL TERMS

	FUNDING SUMMARY					
	Prior Years		Current Year		Future Years	
	FY	Amount	FY	Amount	FY	Amount
PRICE IS ESTABLISHED THROUGH: (CHECK 1,2, OR 3)						
OPTION 1: PRICE AGREEMENT (list price) \$ rate regulation (if any)						
OPTION 2: SUMMARY BUDGET (* lines only) unit rate cost reimbursement other						
OPTION 3: COMPLETE BUDGET cost reimbursement unit rate other						
	Tot:		Tot:		Total: \$	
	Multi-Year Total:					
CURRENT MAX OBLIGATION:\$	UNIT RATE:\$		per		# BILLABLE UNITS:	
ADDITIONAL PAYMENT OR PRICE SPECIFICATIONS:						

If Federal Funds, CFDA #:

Program Name:		Document ID#:				MMARS Code:		Program Type		UFR Prog. #
		Current		Amend. Change		New				
		FTE	Amount	FTE	Amount	FTE	Amount	COST REIMBURSEMENT ONLY		
	Program Component							**Offset	Source	Reimbursable Cost
UFR Title #	Direct Care/Program Support Staff/Overtime/Shift Differential & Relief (Titles 101-141)									
	SUBTOTAL STAFF									
150	Payroll Taxes									
151	Fringe Benefits									
T	Total Direct Care/Program Staff									
Title	Occupancy									
301	Program Facilities									
390	Fac. Oper/Main/Furn									
T	Total Occupancy									
UFR Title	Other Direct Care/Program Support									
201	Direct Care Consultant									
202	Temporary Help									
203	Clients/Caregivers. Reimb/Stipends									
206	Subcontract Dir.Care									
204	Staff Training									
205	Staff Mileage/Travel									
207	Meals									
208	Contracted Client Trans.									
208	Vehicle Expenses									
208	Vehicle Depreciation									
209	Incid. Health/Med Care									
211	Client Per. Allowances									
212	Prov. of Material Good									
214	Direct Client Wages									
214	Other Commercial Prod. & Svs.									
215	Program Supplies/Mat									
T	Total Other Direct Care/Program									
Title	Direct Admin Expenses									
2160	Program Support									
410 & 390	Other Direct Administrative Expenses									
T	Total Direct Administrative Exp.									
T	SUBTOTAL PROGRAM COSTS									
410 T	Agency Admin. Support Allocation	\$								
T	Commercial Earn. Factor, if applicable	\$								
T	PROGRAM TOTAL									

01/17/01



FY _____ Contractor Name _____ Amend #, If Appl.: _____ If Federal Funds, CFDA #: _____
(for internal DMR use) within FY amendment #: _____

ATTACHMENT 4: RATE CALCULATION/MAXIMUM OBLIGATION CALCULATION PAGE

Modified Attachment 4: to be used with all Dept. of Mental Retardation contracts

Program Name:	Document ID#:	MMARS Code:	Program Type	UFR Prog. #
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AMENDMENT #, IF APPLICABLE: _____

UNIT RATE CALCULATION

- | | <u>Source</u> | <u>Amount</u> |
|--|--------------------|----------------------|
| 1. Program Total Costs: | | |
| 2a(1). Program offsets applied to occupancy and meals: | _____ | _____ |
| | _____ | _____ |
| 2a(2). Program offsets applied to non-occupancy and meal items | _____ | _____ |
| | _____ | _____ |
| 2b. Offsets for Non-Reimbursable Costs: _____ | | |
| Note: Total non-reimbursable costs listed in line 2b must be detailed on Attachment 5. | | |
| 2. Subtotal Offsets (Line 2a(1) + Line 2a(2) + Line 2b) | | (_____) |
| 3. Net Adjusted Program Costs (LINE 1 minus LINE 2) | | _____ |
| 4. Total Program Capacity _____ (# of units) | | _____ (Type of unit) |
| 5. Share of Total Capacity Purchased by Contract _____ (# of units) | | _____ (% of line 4) |
| 6. Negotiated Utilization Factor, if any _____ | | |
| 7. Adjusted Capacity Used to Establish Price (LINE 4 x LINE 6) | _____ (# of units) | |
| 8. Unit Rate (LINE 3 DIVIDED BY LINE 7) | | _____ |
| 9. Maximum # of Billable Units (LINE 5 x LINE 6) | | _____ |

OTHER PRICE CALCULATION METHOD

10. Enter relevant information: _____

MAXIMUM OBLIGATION CALCULATION

11. For Unit Rate: Line 8 X Line 9
For Other Price Calculation Method, Enter Obligation From Line 10
For Cost Reimbursement: Enter Reimbursable Cost Total From Program Budget

- | | <u>SOURCE</u> | <u>AMOUNT</u> |
|--|---------------|---------------|
| 12. Invoice Offset | | |
| 12. Subtotal | | (_____) |
| 13. Maximum Obligation for the Program (LINE 11 minus LINE 12) | | |
| 14. Capital Budget (from Capital Budget Form), if applicable | | ===== |
| 15. Total Maximum Obligation for Program (LINE 13 + LINE 14) | | |

FOR INFORMATION ONLY:

Other Revenue Sources (Only if % in LINE 5 is less than 100%)

SOURCE AMOUNT